BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **CAROL L. HENRICKS, M.D.** Holder of License No. 25445 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-05-1202B **CONSENT AGREEMENT FOR LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Carol L. Henricks, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that she has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

Carol L. Henricks DATED: 1-31-07

CAROL L. HENRICKS, M.D.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 25445 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-1202B after receiving notification of a malpractice settlement involving Respondent's care and treatment of a fifty-five year-old female patient ("JD").

4. On November 28, 2003, at 10:05 p.m. JD presented to the emergency room complaining of progressive lower extremity numbness and tingling. The emergency room physician ordered a magnetic resonance imaging ("MRI") scan of the "thoracic spine from 8 down through L-5 spine" and performed a spinal tap and an examination. The examination was significant for absent vibration and pain sensation in the entire right leg up to the mid abdomen at approximately T10. The emergency room physician noted bilateral lower extremity ataxia, "cerebellar signs" and brisk reflexes. The MRI was essentially normal and the spinal tap revealed increased protein. The emergency room physician contacted Respondent for a consultation and based on the emergency room physician's presentation Respondent recommended JD obtain a thoracic and lumbar MRI and plain films to exclude a right T10 cord lesion. The films were negative and did not explain JD's neurologic signs and symptoms. Respondent then recommended a lumbar puncture that was performed by the emergency room physician. The puncture revealed an elevated cerebral spinal fluid protein.

5. Respondent presented to the hospital on November 29, 2003, and examined JD. Based on her examination, JD's elevated protein and JD's signs and symptoms, Respondent diagnosed JD with post-infectious acute transverse myelitis without first

ordering a complete spinal MRI to rule out a compressive cervical cord lesion. On November 30, 2003, Respondent noted JD showed mild improvement; however, Respondent did not document a neurologic examination to support this improvement in JD's neurologic function. Furthermore, the nursing notes from that day did not show any neurologic improvement compared to prior neurologic checks. At 11:00 p.m. JD developed spasms in her legs and was given Ativan to sleep.

6. On December 2, 2003, JD began experiencing upper and lower extremity spasms and on December 3, 2003 at 3:30 a.m. JD complained of left shoulder severe pain and shooting spasms throughout her body. The nurse noted JD "was unable to sit up and had to be lifted up in bed" and at 6:00 a.m. noted JD experienced "new hand numbness." At 8:00 a.m. JD "lost ability to feel or move her lower extremities" and she lost the urge to void her bladder. The nurse contacted Respondent and informed her of JD's condition. Respondent ordered a STAT MRI, but nursing notes reflect they told Respondent the earliest available MRI would be 3:00 p.m. that day. Respondent examined JD at 9:00 a.m. and noted JD had low systolic blood pressure, she was numb from the chest down, she could no longer move her legs, she had a bilateral weak grasp and JD could not hold her arms above her head. Respondent felt these new neurological signs suggested an "aggressive Transverse Myelitis" and recommended a cervical, thoracic and lumbar MRI and lumbar puncture. JD was transferred to the intensive care unit where an MRI was conducted at 6:00 p.m.

7. The radiologist ("Radiologist #1") reviewed the MRI and reported "possible cervical cord compression by a possible subluxation of C5-6 and also disc disease." Radiologist #1 requested JD undergo additional MRI sequences of the cervical spine, including the saggital T2, because the images he viewed were taken under a Guillain-Barre study centering on images of the thoracic and lumbar spine, not the cervical spine,

making them hard to read. Radiologist contacted Respondent and left a message on her answering machine requesting the additional MRI sequences. JD underwent a subsequent MRI at 10:14 p.m., but the films were not read by Respondent or a physician in the radiology department until the next day.

8. On December 4, 2003 at 1:40 a.m. Respondent performed a lumbar puncture. The radiologist ("Radiologist #2") reviewed the MRI films performed at 10:14 p.m. the night before and reported a large osteophyte at C5-C6 with a disc herniation at C6-C7 and extrusion of disc material. Radiologist #2 noted he discussed with Respondent at 8:00 a.m. that the combination of findings were causing a very severe central spinal stenosis from the inferior of C5 to the top of C7 indicating evidence of cord edema. At 8:45 a.m. Respondent and neuro-radiology reviewed the MRI films performed at 10:14 p.m. the night before and noted an "unexpected disc herniation at C7-T1 level with cord edema." JD underwent emergency surgery for the disc herniation at 11:00 a.m. By that time, JD had suffered approximately thirty-two hours of paraplegia resulting in permanent severe cord injury and disability.

9. On May 14, 2004, JD was readmitted to the hospital with shortness of breath. JD developed deep vein thrombosis and bilateral pulmonary emboli and was started on Coumadin. Her history indicated that since the development of her quadriplegia she also developed stage IV sacral decbitus and lower extremity pressure skin ulcers.

10. The standard of care requires a physician to rule out a compressive cervical cord lesion as a cause for the patient's neurologic signs and symptoms prior to diagnosing acute transverse myelitis.

11. Respondent deviated from the standard of care because she did not rule out a compressive cervical cord lesion prior to diagnosing JD with acute transverse myelitis.

12. Respondent's delay in diagnosing compressive cervical myelopathy by an intervertebral disc herniation led to JD developing cervical spinal cord ischemia, stage IV sacral decbitus, lower extremity pressure skin ulcers and inflammation, causing extremity spasms, pain, autonomic dysfunction and quadriplegia.

13. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because Respondent did not document the examination she performed to support JD's improvement in neurologic function.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient") and A.R.S. § 32-1401 (27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for failure to diagnose a compressive cervical myelopathy by an intervertebral disc herniation in a timely manner and for failure to maintain adequate medical records.

2. This Order is the final disposition of case number MD-05-1202B.

DATED AND EFFECTIVE this 13th day of April, 2007.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of April, 2007 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 13th day of April, 2007 to:

Carol L. Henricks, M.D.
Address of Record

_____
Investigational Review